other marketing materials that the sites wish to disseminate to beneficiaries shall be submitted to TMA, Special Programs and Demonstrations, for prior approval. Subsequent to initial marketing, approval of site-specific marketing materials shall be forwarded to the Lead Agent for coordination and approval by the Regional HCFA Office.

c. *The contractor shall be responsible for the proposal and development of flyers to announce educational meetings including the number of flyers and how they will be distributed. Flyers shall be prepared and submitted to the Lead Agent for approval no later than forty-five (45) days prior to the start of marketing. The flyers will be approved and returned to the contractor for printing and distribution no later than thirty (30) days prior to the start of marketing. No later than fifteen (15) days prior to marketing, the contractor shall display the flyers and posters in prominent places announcing the advent of marketing.*

d. *The contractor shall support educational meetings starting two months prior to the start of health care delivery and continuing, as needed, through the enrollment period in each demonstration site to fully explain the demonstration, including information about limited enrollment capacity, program benefits, the impact of enrollment on an applicant's eligibility for other Medicare-covered services, "lock-out," implications of dropping Medicare supplemental insurance, and other MHS health care services. Educational meetings shall be concentrated during the first two weeks of the marketing period. The contractor shall propose the number of meetings to be held at each site, considering the number of Medicare-eligible beneficiaries in the area and the enrollment capacity of the MTF. The educational meetings shall be held on the military installations participating in the demonstration program, or at off-site locations mutually agreed upon by the contractor, Lead Agent, and the MTF Commander. In the event that capacity is reached prior to the end of the open enrollment period, the contractor shall widely publicize that capacity has been reached and that applications are no longer being accepted.*

e. *The contractor shall not release enrollment applications until the first day of marketing (two months prior to the start of health care delivery).*

4. *Eligibility/Enrollment*

a. *Eligibility*

(1) *A beneficiary must meet all of the following eligibility requirements. An eligible beneficiary:*

(a) *is Medicare eligible, on the basis of age, on or prior to the first day of health care delivery [see also Section II.N.4.c. for instructions regarding "aging-in"],*

(b) *is eligible for care in the Military Health System,*

(c) *is entitled to Medicare Part A,*

(d) *is enrolled in Medicare Part B,*

(e) *lives within the MTF catchment area, and*

(f) *has received services as a dual eligible prior to July 1, 1997, or became eligible for Medicare, Part A on or after July 1, 1997.*

EXCEPTION:

A beneficiary who has been diagnosed with end stage renal disease (ESRD) or who has elected the Hospice benefit under Medicare, is not eligible to enroll, except as provided under Section II.N.4.c. (aging-in). A beneficiary with a diagnosis of ESRD and/or who lives outside the service area of the demonstration site may age in. (A beneficiary who is diagnosed with ESRD or who elects the Medicare Hospice benefit while enrolled is eligible to remain in TRICARE Senior Prime.)

(2) *The demonstration area is defined as the zip codes within the specified MTF catchment areas. Beneficiaries living outside of the catchment areas are not eligible to enroll, except for those beneficiaries who are eligible to "age-in" to the demonstration as defined in Section II.N.4.c. (Beneficiaries shall not be disenrolled if the Postal Service changes their zip code which places them outside of the catchment area.)*

(3) *Under this demonstration, enrollees are not subject to an enrollment fee, but shall be subject to cost-shares in accordance with the attached matrix of benefits, which conform with the TRICARE Prime benefit package with several exceptions (e.g., skilled nursing facility (SNF) care, respite care). Cost-shares for SNF and respite care are the same as under Medicare Part A. (Figure 2-20-N-3). There is no catastrophic cap or deductible collected or credited for care received under this demonstration. Point of Service does not apply; Portability does not apply.*

b. *Enrollment Process*

(1) *The contractor shall provide a written enrollment plan to the Lead Agent (with a copy to the COR) for approval not later than forty-five (45) days prior to the start of enrollment. Feedback will be provided no later than 15 days following submission of the plan. The contractor shall establish an enrollment process that provides a fair and equitable opportunity for beneficiaries to obtain information about the TRICARE Senior Prime option and provides an opportunity for them to submit applications. This process shall include the following activities at a minimum:*

(a) *The contractor shall distribute enrollment packages at sites convenient to eligible beneficiaries, including at the educational meetings, the TRICARE Service Center, the MTF, and other sites as agreed upon by the contractor and MTF Commander/Lead Agent, no earlier than the first day of marketing. The contractor shall also mail enrollment packages to beneficiaries who request them by telephone.*

(b) *The contractor shall provide telephone lines and adequate numbers of trained staff at the TRICARE Service Center to review applications, provide assistance completing applications, provide applications by mail, if requested, schedule appointments and conduct face-to-face interviews, if requested by the beneficiary. The contractor shall meet all established contract requirements and performance standards for the TRICARE Service Center and telephone service unit.*

(c) *The contractor shall provide in the enrollment application package a preaddressed return envelope with the contractor's address. The envelope must have imprinted on the outside in large lettering, "must NOT be postmarked prior to (date to be determined by TMA)" to ensure that applicants clearly see that it should not be mailed early.*

(2) *The contractor shall conduct an open enrollment season for at least thirty (30) days in the first year of the demonstration. A thirty (30) day open enrollment season in subsequent years shall be conducted by a subsequent contract modification upon direction from the Lead Agent, based on enrollment capacity at participating sites. However, enrollment status of the Medicare enrollee in TRICARE Senior Prime shall be continuous, with an indefinite end date entered into CHCS (MCP). (See Figure 2-20-N-4).*

(3) *Enrollment applications shall be accepted by mail only. The contractor shall date stamp all applications with the date of receipt. Application envelopes postmarked earlier than the start of the open enrollment period (15 days after the start of marketing) shall be returned to the applicant with an appropriate letter of explanation. The contractor shall retain a copy of the application and the postmarked envelope for one year from date of receipt. Applications are for individual enrollment only and shall be processed on a first come, first served basis. However, in households with more than one eligible beneficiary, the applications may be submitted in one envelope and shall be processed together. If both applicants are eligible and there is space for one of the applicants, both shall be enrolled.*

(4) *The MPC on behalf of the contractor shall, on a daily basis, compile a list of applications processed that day. In order of receipt, the contractor shall verify all information in a face-to-face interview or by telephone contact (Medicare HMO/CMP Manual, 2001.5).*

(a) *The contractor shall make at least two attempts to make telephone contact within the first ten (10) working days after receipt of an application. These attempts will be documented on the MPC system. In the event that telephone contact is not achieved, the contractor shall, within twelve (12) working days of receipt of an application, send a letter requesting that the applicant call to verify information on the enrollment form, allowing three mail days, which would not include Sundays or holidays, but would include Saturday. The letter shall clearly inform the applicant that failure to respond within 29 calendar days will render their application inactive. This letter will be automatically generated by the MPC system. If the applicant does not respond within 29 calendar days to the automated letter generated by the MPC, the MPC system will automatically render the application inactive. The contractor shall place that beneficiary at the top of the waiting list. When the applicant contacts the contractor and completes the application process, the applicant shall be enrolled at the next available slot.*

(b) *Documentation of telephone contact or attempts to contact an applicant shall comply with current contract requirements. The purpose of the telephonic contact is to review the application with the potential enrollee, obtain additional information as necessary to complete the application, and determine the applicant's understanding of the program. If requested, an appointment for a face-to-face interview shall be scheduled within a reasonable time to permit the applicant to make a final decision regarding enrollment.*

(c) *If the contractor is unable to contact the applicant, either by telephone or mail, the application shall become inactive within thirty-five (35) days of receipt. The contractor shall retain a copy of the application and all relevant documentation for the file, return the remaining copies to the applicant with a letter explaining that enrollment has not been approved and the reason for disapproval.*

(d) *The contractor shall provide each applicant with a copy of his/her completed, signed, and dated application (Medicare HMO/CMP Manual 2001.6).*

(5) *The contractor shall verify eligibility as defined in Eligibility/Enrollment (see Section II.N.4. of this section), to include those applicants who will be placed on the waiting list, via:*

(a) *An inquiry of the Defense Enrollment Eligibility Reporting System (DEERS) through the Medicare Processing Center as defined in Section II.N.6. Interface with HCFA to verify eligibility for the MHS, the applicant's age, address, and zip code.*

(b) *Self-declaration on the enrollment form of use of the MTF as a dual-eligible.*

(6) *An application may be pended for further clarification. Reasons for pending include:*

(a) *The contractor's inability to reach an applicant by telephone as required under Section II.N.4.b.(4) above, and*

(b) *A discrepancy between DEERS and an applicant's assertion that he/she is eligible for care in the MHS. In this case, the applicant shall be given an opportunity to correct DEERS.*

(7) *If the contractor discovers a discrepancy between an applicant's current, verified address on the enrollment form and HCFA, the contractor shall inform the applicant that the address should be corrected. If there is a discrepancy between the current address and the DEERS address, the contractor shall correct the DEERS address when entering the enrollment in CHCS.*

(8) *The contractor shall produce the enrollee identification cards similar in style and size to those provided to TRICARE Prime enrollees. The card must have the program name TRICARE Senior Prime on the card. Other informational elements on the card are at the discretion of the Lead Agent and shall be included in the MOU.*

(9) *The contractor shall provide the enrollee with written confirmation of the enrollment effective date, an enrollment card, and applicable enrollment materials as discussed in Section II.N.3. and Section II.N.10.g. Refer to Section II.N.6., below, for instructions on enrollment confirmation with HCFA and procedures for establishing enrollment dates. All enrollment materials shall be mailed to the beneficiary within two (2) working days of notification from HCFA of their enrollment effective date.*

(10) *Annual open enrollment periods may be exercised at the option of the Government by subsequent modification. The contractor shall consult with the MTF/Lead Agent ninety (90) days prior to the end of each enrollment year regarding the necessity for an open enrollment period.*

(11) *Upon reaching enrollment capacity, the MPC will establish a wait list of eligible applicants at the level reflected in Figure 2-20-N-1. The MPC will notify the contractor as part of the monthly reporting requirement regarding available spaces. When space is available, the contractor shall offer applicants on the wait list an opportunity to enroll*

and shall verify all information on the original enrollment form to ensure its continuing accuracy.

(12) *Once capacity is reached, the contractor shall notify all unsuccessful applicants using the appropriate letter developed for that purpose.*

c. *Aging In*

(1) *During initial open enrollment, any TRICARE Prime enrollee with a PCM at the MTF health care delivery site who becomes Medicare eligible on the basis of age, on or after the date health care delivery begins, shall be offered enrollment on an "aging-in" basis.*

(2) *Notwithstanding capacity limits, enrollees in TRICARE Prime who are assigned to a primary care manager at a participating MTF, attain age 65, meet other eligibility requirements and, desire to enroll in TRICARE Senior Prime shall be enrolled. TRICARE Prime enrollees who: are assigned to a primary care manager at a participating MTF and meet all eligibility requirements except ESRD and/or residence in the service area, and desire to enroll in TRICARE Senior Prime, shall be enrolled upon signing a waiver of access standards.*

(3) *The MTF shall provide information to the contractor on Primary Care Managers with panel openings for selection by the enrollee. As detailed in Section II.N.6., the MPC will track TRICARE Prime enrollees, and 150 days prior to the TRICARE Prime enrollee becoming Medicare eligible on the basis of age, will notify the contractor. The contractor shall, 120 days prior to the enrollee becoming Medicare eligible on the basis of age, provide information to the enrollee regarding TRICARE Senior Prime and their opportunity to enroll. The beneficiary must return the application to enroll into TRICARE Senior Prime to the contractor no later than 60 days prior to his/her becoming Medicare eligible on the basis of age. Enrollment data for a beneficiary aging-in to the TRICARE Senior Prime option must be submitted to HCFA not later than thirty (30) days prior to the individual becoming eligible for Medicare.*

5. *Health Promotion/Clinical Preventive Services*

a. *The contractor shall provide the Health Evaluation Assessment Review (HEAR) to each enrollee at the time the initial TRICARE Senior Prime identification card is provided (except for TRICARE Prime enrollees aging-in to TRICARE Senior Prime or if the enrollee has completed a HEAR within the past 18 months). An applicant's failure to return the survey does not affect his or her enrollment in TRICARE Senior Prime. The contractor shall follow up on unanswered surveys within sixty (60) days with at least one (1) written or one (1) telephonic contact. If follow-up attempts are not successful in obtaining a response, the contractor shall document that instance for the record. Such documentation shall be assessable for monitoring purposes.*

b. *The contractor shall provide enrollee HEAR data survey result reports to the enrollee and the MTF within fifteen (15) days of receipt of the HEAR. Reporting of this information is on-going to the extent that surveys continue to be received from enrollees. Enrollees' HEAR data shall be provided to the government in an electronic medium in a form that can be manipulated by the government.*

c. *The contractor shall include TRICARE Senior Prime enrollees in all on-going requirements for HEAR surveys as are specified in the MCS Regional TRICARE Contract.*

d. *The contractor shall also provide each enrollee with an age appropriate self-intervention manual which has been approved by the Lead Agent, and a Health Care Information Line pamphlet, explaining the 24-hour nurse line at the same time (but not necessarily in the same mailing), as the Coverage Agreement, and TRICARE Senior Prime identification card is provided. The contractor shall ensure that the TRICARE Senior Prime enrollees receive all other health promotion materials and have access to activities available to TRICARE Prime enrollees, as detailed in the TRICARE contract.*

6. *Interface with HCFA - Medicare Processing Center (MPC)*

a. *The MPC is a front end processor that the contractor shall use for all electronic communications with HCFA, (see Figure 2-20-N-4). The MPC simplifies communication and improves data quality for all demonstration participants. For HCFA, the MPC is an experienced processor and user of all required systems. The MPC has the ability with their existing communications infrastructure and access to perform required processes without involving multiple processors. The MPC will gather data from the MCSCs, DEERS, and CEIS; perform data manipulation as necessary and provide a single feed to HCFA. For DoD, the MPC will feed needed Medicare data to the MCSCs and CEIS. The MPC also processes reconciliations of enrollment and encounter data to insure that HCFA and DoD are in sync, a requirement for demonstration audit and validation. For the MCSCs the MPC provides a single on-line eligibility verification and enrollment system. Figure 2-20-N-5 provides charts showing the data flow.*

b. *The contractor shall participate in planning meetings with the government and MPC personnel. These meetings will define details of data exchange, on-line entry, and other issues to support this demonstration. The contractor shall travel to a central site for two meetings of approximately three (3) days duration. The contractor shall pay their own travel and per diem. The meeting support costs will be borne by the MPC.*

c. *The MPC will provide the contractor with training at the contractor designated site. The contractor shall provide the space and workstations sufficient for their personnel to be trained. Training should take approximately three (3) days. Two shifts of 2 ½ days each will be provided if necessary.*

d. *The contractor shall conduct application processing on the MPC system. The contractor gains access through the MPC provided dial-up access, or through a dedicated line. MPC provides the data line if the contractor is processing applications from a central site. All equipment at the contractor end is the responsibility of the contractor. The contractor shall contact TMA, Special Programs and Demonstrations, (703) 681-1759 with any systems questions. DEERS access is imbedded into the MPC system. The MPC also maintains the most current Medicare eligibility status data; i.e., ESRD, Part B, MSP Working Aged, Hospice, State Buy-In, etc., on those MHS eligibles identified as residing in the service area. When the contractor conducts the DEERS eligibility check through the MPC, the system populates the enrollment screen with information from DEERS and HCFA as available, thus simplifying the entry process.*

e. *Completed applications received by the contractor by the 25th of the month shall be entered into the MPC system by the close of business on the second workday of the following month.*

f. *The MPC will provide the contractor with a monthly transaction report that notifies the contractor of enrollment confirmations and errors. The monthly report will also provide the contractor with all other eligibility and enrollment changes. The contractor shall provide a copy of the monthly transaction report to the Lead Agent within five calendar days of receipt from the MPC.*

g. *Following receipt of the monthly transaction report from the MPC, the contractor shall provide the enrollee with written notification of the enrollment effective date, enrollment card and applicable enrollment materials. All materials shall be mailed to ensure receipt by the beneficiary at a minimum of three (3) working days prior to the enrollment effective date. With the same mailing and where required by their contract, the contractor shall also provide the beneficiary with the Health Evaluation Assessment Record form and the self intervention manual; however, an applicant's failure to return the survey does not affect their enrollment in the demonstration project. The contractor shall not enroll a beneficiary in CHCS until confirmation of the applicant's enrollment in HCFA has been received. The contractor shall enter the enrollment into their internal system, if necessary, and into CHCS.*

h. *The contractor shall enter the alternate care code of "D" into DEERS via CHCS/MCP to identify the beneficiary as a Medicare Demonstration enrollee. The contractor shall verify the enrollment action entered in both DEERS and CHCS/MCP is correctly reflected on both systems within one (1) working day following the initial entry of the information into CHCS/MCP and DEERS.*

i. *The MPC will provide the contractor with activity, error, and other reports that require the contractor to process changes regarding enrollment data bases (contractor, CHCS/MCP and DEERS) to reflect all changes within twenty-one (21) calendar days of receipt of the report.*

7. Retroactive Enrollment

Retroactive enrollments shall be processed only in the event that enrollment was denied because an error or technical problem in the HCFA system resulted in the provision of inaccurate beneficiary information. Such applicants shall be enrolled regardless of capacity limits and shall be entered into DEERS through CHCS (MCP).

8. Records Retention

a. *The contractor shall ensure that all enrollment and disenrollment forms are signed and dated. All applications shall be filed by applicant's SSN and segregated between those that were approved and those that were denied. Files for applications that were denied shall contain all supporting documentation regarding the rationale for the denial (including the envelope in which it was received). For all enrollment applications, all associated development, letters to beneficiaries, confirmation or denial notifications from HCFA, annotations of the mailing date of the enrollment card and associated enrollment materials, etc., shall be maintained with the enrollment application. The contractor shall retain all enrollment applications while the beneficiary is enrolled in TRICARE Senior Prime and for one (1) year after disenrollment. The contractor may retain enrollment/disenrollment forms,*

and other documentation identified above, either in hard copy, readable microfilm, or electronic media/CD, as long as these versions of storage are readily available for review and the signature and the date on the forms are clearly readable. After one (1) year from disenrollment, the contractor shall follow the records management requirements in the OPM Part One, Chapter 2.

b. *The contractor shall retain on active files all reconciliation data received from HCFA for one (1) year from the date of receipt and then follow the procedures in the OPM Part One, Chapter 2 for records retention. The contractor shall propose the site at which all documentation will be retained.*

9. *Disenrollment*

a. *An enrollee may be involuntarily disenrolled for:*

(1) *Failure to Maintain Medicare Part B*

Upon notification by HCFA that an enrollee is no longer eligible for enrollment, the contractor shall disenroll the enrollee on the date specified by HCFA. The contractor shall notify the enrollee and the MTF Commander within two (2) working days of notification from HCFA. The contractor shall enter the disenrollment into CHCS-MCP.

(2) *Failure to Comply with Requirements of TRICARE Senior Prime, or for Disruptive or Abusive Behavior*

The contractor shall involuntarily disenroll an enrollee only upon final notification of such a determination by HCFA. Twenty days in advance of the disenrollment, the contractor shall notify the affected beneficiary, by certified mail, of the pending disenrollment (see Figure 2-20-N-6). The involuntary disenrollment date shall be effective in accordance with HCFA's determination. An enrollee shall NOT be disenrolled for exercising his/or her option to make treatment decisions with which TRICARE Senior Prime disagrees. The contractor shall enter the disenrollment into CHCS-MCP.

(3) *Moving Outside of the Approved Service Area for More than Ninety (90) Consecutive Days*

In the event that an enrollee is identified as being outside of the service area for more than ninety (90) consecutive days, the contractor shall notify the MTF Commander/Lead Agent. The contractor shall involuntarily disenroll the enrollee only upon direction of the MTF Commander/Lead Agent. Within two (2) working days of receipt of such notice and in no less than 29 days prior to the disenrollment effective date, the contractor shall notify the affected beneficiary by certified mail of the disenrollment. Involuntary disenrollment shall be effective in accordance with HCFA determination. (See Figure 2-20-N-6.) The contractor shall enter the disenrollment into CHCS-MCP.

b. *An enrollee may disenroll at any time by submitting a written request. The contractor shall acknowledge receipt of the disenrollment request and include a copy of the enrollee's request. Within two (2) working days of receipt of the request, the contractor shall update CHCS/MCP and its own internal system. The contractor shall process voluntary disenrollments in accordance with the HCFA HMO/CMP Manual, Section 2004.8.*

c. *An enrollee who disenrolls or is disenrolled involuntarily may request reenrollment at the next enrollment period.*

10. Access to Network Providers

a. *The same access standards for network services in place for TRICARE Prime shall apply under this demonstration.*

b. *The contractor shall, in consultation with the Lead Agent and MTFs, develop a network of providers to augment the health care services available in the MTF. The contractor shall ensure that the network includes a sufficient number and mix of providers that, in conjunction with the MTF providers, assures appropriate services are available for the population enrolled. If the contractor provides documentation of efforts to negotiate rates, and there is no other accessible provider of the needed specialty available, the Lead Agent may approve payment up to the Medicare rate, if necessary, to secure a network specialty provider agreement for a needed service. Upon direction of the contracting officer, the contractor shall provide, the following:*

(1) *A list of TRICARE network providers who have agreed to participate in TRICARE Senior Prime;*

(2) *Service area maps showing the location of the TRICARE Senior Prime network providers;*

(3) *For each category of providers, specimen copies of agreements between the contractor and the network providers which govern the provider's participation in TRICARE Senior Prime, and*

(4) *A schedule showing how many agreements have been signed to date and a statement as to the date the remaining agreements will be completed.*

c. *The contractor shall ensure that network providers agree to accept referrals for enrollees and to provide clinical feedback to the MTF for care provided to an enrollee consistent with existing practices for TRICARE Prime. At the time of the HCFA site visit, the contractor shall make available for HCFA's viewing, the signed agreements between the contractor and all TRICARE Senior Prime providers.*

d. *The Primary Care Manager (PCM) for enrollees in TRICARE Senior Prime shall always be an MTF provider. For services not available within the MTF, the same referral and authorization process under TRICARE Prime shall be utilized, except that any referrals to non-network providers found to be medically necessary and appropriate shall be referred to the MTF Commander or designee prior to authorization. The MTF Commander or designee will provide a response within one (1) working day.*

e. *The contractor shall ensure that referrals are to a network provider, if required services are available in the network. If a network provider is not available for referral, authorization must be approved by the MTF Commander or his/her designee. The contractor shall, upon consultation with the Lead Agent regarding non-network provider referral volume, enhance the network as appropriate.*

f. *The Medicare benefit includes coverage of manual manipulation of the spine (to treat subluxation demonstrated by x-ray) and is a covered benefit under TRICARE Senior Prime. The contractor shall obtain a network provider capable of delivering this benefit, in accordance with the applicable state laws (Figure 2-20-N-7).*

g. *Upon direction of the contracting officer, the contractor shall provide to the Lead Agent and TMA, a draft TRICARE Senior Prime Provider Directory that includes a listing of the MTF providers. The contractor shall also provide, under separate cover, a map plotting the locations of network providers. The final TRICARE Senior Prime Provider Directory shall be available for distribution at the time (but not necessarily in the same mailing), as the Coverage Agreement and the TRICARE Senior Prime identification card are provided to enrollees.*

11. *Training of Providers*

The contractor shall ensure that all MTF and civilian network providers serving TRICARE Senior Prime enrollees receive education prior to the date of the HCFA site visit, as notified by TMA, for both the TRICARE and Medicare programs. The contractor shall ensure that those providers shall have ongoing access to information about these programs. The training and information provided to both MTF and network providers shall include the process for referrals and the use of the health care finder. The contractor shall develop an addendum to the network provider manual that clearly explains the Medicare benefit and TRICARE Senior Prime and shall ensure that TRICARE Senior Prime is included in all on-going provider training conducted in compliance with training requirements under the current contract. The contractor shall make all such information available to MTF providers.

12. *Benefits*

The benefits to be delivered under the demonstration shall include all services and supplies covered by the Medicare Program, plus additional services not covered by Medicare as follows: outpatient pharmacy services and preventive services. The TRICARE Prime Program shall be the vehicle for delivery of the benefit package, except that standard Medicare coverage of skilled nursing facility care, home health care, and chiropractic services will apply. The contractor is responsible for determining and applying the Medicare coverage for these benefits, including local/regional policies if applicable. Claims shall not be denied based on TRICARE benefit policy without first reviewing to determine if the service is covered under Medicare policy. The benefit package and cost-share structure as defined in Figure 2-20-N-3 mirrors the TRICARE Prime benefit, with the following exceptions:

a. *Enrollment in the TRICARE Senior Prime does not require an enrollment fee.*

b. *Skilled Nursing Facility (SNF) care is covered, in accordance with Medicare rules, at no cost to the beneficiary for the first twenty (20) days. An additional eighty (80) days may be authorized with a beneficiary cost share in accordance with the current Medicare rate. The Medicare skilled nursing facility benefit is limited to 100 medically necessary days in a benefit period. A benefit period begins the day the patient is admitted to the hospital, and ends when he/she has been out of a hospital or SNF for 60 consecutive days, including the day of discharge. It also ends if the beneficiary stays in a SNF, without receiving SNF care for 60 consecutive days. Once a benefit period ends, a new benefit period begins and hospital and SNF benefits are renewed. There is no limit to the number of benefit periods. The contractor shall track the number of beneficiary days in which a TRICARE Senior Prime enrollee is an inpatient in a skilled nursing facility to ensure application of appropriate cost shares.*

c. *The contractor shall track the number of inpatient mental health days used by an individual enrollee. Such information shall be retained in a form readily*

accessible for provision to HCFA upon an enrollee's disenrollment from TRICARE Senior Prime or the end of the demonstration.

d. *Manual manipulation of the spine, if subluxation is identified by a Medical Doctor or Doctor of Osteopathy by x-ray, may be performed by a chiropractor, a physician or by non-physician practitioners, such as physical therapists, if allowed under applicable state law.*

e. *The definition for emergency and urgent care shall be that of Medicare, as follows:*

(1) *"Emergency services" means covered inpatient and outpatient services that are:*

(a) *furnished by an appropriate source other than the organization;*

(b) *needed immediately because of an injury or sudden illness; and*

(c) *needed because the time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health. Such services must be, or appear to be, needed immediately. (Figure 2-20-N-8 provides further explanation of emergency services.)*

(2) *"Urgent services" are Medicare covered services required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or injury. Cover these services if:*

(a) *The enrollee is temporarily absent from the MTF's geographic area, and*

(b) *The receipt of health care services cannot be delayed until the enrollee returns to your organization's geographic area. The enrollee is not required to return to the service area because of the urgently needed services. (Figure 2-20-N-8) provides further explanation of urgent services.)*

f. *To qualify for home health care, a TRICARE Senior Prime enrollee must be homebound according to the Medicare definition; require intermittent skilled nursing, physical therapy, or speech therapy; and be under the care of a physician. In addition, the services must be furnished under a plan of care that is prescribed and reviewed at least every 62 days by a physician. If these conditions are met, TRICARE Senior Prime will pay for skilled nursing; physical, occupational, and speech therapies; medical social services; home health aide visits; durable medical equipment and medical supplies. As long as the care is reasonable and necessary and meets the above criteria, there are no limits on the number of home health visits or length of coverage.*

g. *Enrollees are entitled to all pharmacy services available to TRICARE Prime enrollees.*

h. *The TRICARE Prime Point of Service Option is not applicable to this demonstration.*

13. Claims

a. General

(1) *The MCS contractor shall adjudicate claims for all health care services provided to TRICARE Senior Prime enrollees by both network and non-network providers. The MCS contractor shall not be financially at-risk for payment of these claims, but shall be reimbursed by the TRICARE Management Activity.*

(2) *All rules applicable to processing claims for TRICARE Prime to include, eligibility verification, health care finder authorization verification, other health insurance (OHI), third party liability (TPL), TRICARE ClaimCheck, TRICARE payment/check release, etc., shall apply, except those specifically excluded non-network provider services. Claims shall not be denied based on TRICARE benefit policy without first reviewing to determine if the service is covered under Medicare policy.*

(3) *Non-Availability Statements (NAS) are not applicable to this demonstration.*

(4) *The point of service option is not applicable to this demonstration.*

(5) *No deductibles or catastrophic cap accumulations are applicable to this demonstration.*

(6) *Prepayment review for care not authorized is applicable to TRICARE Senior Prime, except that, other than emergent or urgent care, non-authorized care is to be denied and the enrollee provided the appropriate letter explaining the denial and the enrollee's appeal rights. Please note that, in conducting prepayment review for emergency services in or out of the service area, and urgent care services when an enrollee is out of the area, approval for payment is dependent on the presenting symptoms and the enrollee's perception of the existence of an emergent or urgent situation, not on the resulting diagnosis. (See Figure 2-20-N-8 for definitions of emergency and urgent care services.)*

(7) *A referral or preauthorization for the care provided must be present on the contractor's system when a claim is being processed for care rendered by a provider outside of the MTF, including preventive care. A referral or preauthorization is not required for: urgent or emergent care, the first eight mental health visits, or for network pharmaceutical services, to include both retail and mail order.*

(8) *For each claim processed for services received outside of the MTF, the contractor shall provide the beneficiary and provider with an explanation of benefits (EOB). The information on the reverse side of the EOB shall be blank. On each EOB processed, the contractor shall include the following message: "This is a claim for TRICARE Senior Prime. No deductibles or catastrophic cap accumulations are applicable to this program."*

(9) *In the event a claim is denied for payment, the contractor shall provide the enrollee and the provider with a letter in addition to the EOB, explaining the reason for the denial and providing appropriate appeal rights.*

(10) *The MCS contractor shall create a HCSR for each network and non-network claim processed to completion and submit to the TRICARE Management*